

MDR Tracking Number: M5-04-3868-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on July 12, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 07-12-04, therefore the following date(s) of service are not timely: 07-09-03.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, processes-group, chiropractic manipulation, Delorme muscle testing, human performance test, ROM, unlisted therapeutic process, massage and copies from 08-01-03 through 09-05-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On August 5, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
07-14-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.

07-16-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.
07-18-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.
07-21-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.
07-25-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.
07-28-03	97150 97250 97265	\$27.00 \$43.00 \$43.00	\$0.00 \$0.00 \$0.00	F F F	\$27.00 \$43.00 \$43.00	1996 MFG	Requestor submitted relevant information to support services rendered. Therefore, these disputed services will be reviewed according to the 1996 Medical Fee Guideline Schedule. Recommend reimbursement of \$113.00.
08-08-03 08-13-03	99080-73 99080-73	\$15.00 \$15.00	\$0.00 \$0.00	V V	\$15.00 \$15.00	Medicare Fee Guidelines, Rule 134.202	The TWCC-73 is not subject to an IRO review. Therefore, will be reviewed in accordance with the Medicare Fee Guidelines. Recommend reimbursement in the amount of \$30.00
TOTAL							The requestor is entitled to reimbursement of \$708.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 07-14-03 through 08-13-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

August 30, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3868-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who

reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: correspondence, office notes, daily progress notes, therapeutic procedures and ROM measurements.

Information provided by Respondent: correspondence and designated doctor exams.

Clinical History:

Claimant underwent physical medicine treatments after developing pain in both hands at wrists at work on ____.

Disputed Services:

Office visits, therapeutic exercises, processes-group, chiropractic manipulation, Delorme muscle testing, human performance test, ROM, unlisted therapeutic process, massage and copies during the period of 08/01/03 through 09/05/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*¹ Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, the treatment rendered in July 2003 would be indicated for this patient. However, since the treatment in this case did not produce the expected positive results, it was not reasonable to continue that course of treatment. There is no documentation of objective or functional improvement in this patient's condition. In fact, the opposite is true since the ranges of motion of both wrists dramatically decreased during the time period of 07/02/03 to 08/06/03.

The records also fail to substantiate that the disputed treatments fulfilled the requirements of Texas Labor Code 408.021 since the patient obtained no significant relief, promotion of recovery was not accomplished and there was no enhancement of

¹ Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

the employee's ability to return to employment. Specifically, the patient's pain rating was 6-7/10 from 07/07/03 to 07/30/03 and was 5-6/10 from 08/01/03 to 09/03/03. Additionally, the examining medical physician reported the patient as "not improved" on 08/05/03 and 09/02/03.

Sincerely,